

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland	c. LENGTH OF STAY IN lb 12 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert Paul Dill		4. DATE OF DEATH March 23 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1916
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Contracting	11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Dill		14. MOTHER'S MAIDEN NAME Emma Becker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 10/12/43		16. SOCIAL SECURITY NO. 213-12-7423	17. INFORMANT Dessie (NAIR) Dill
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, bilateral DUE TO (b) Aortic stenosis with left ventricular hypertrophy DUE TO (c) secondary to old rheumatic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH days Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		DATE SIGNED 3-23-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/59	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) Oakland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland Md.	
24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CLERGY	
19. SIGNATURE OF POLICE		20. SIGNATURE OF SOCIAL WORKER		21. SIGNATURE OF NURSE	
22. SIGNATURE OF PATHOLOGIST		23. SIGNATURE OF ANATOMIST		24. SIGNATURE OF HISTOLOGIST	
25. SIGNATURE OF RADIOLOGIST		26. SIGNATURE OF CLINICAL CHEMIST		27. SIGNATURE OF MICROBIOLOGIST	
28. SIGNATURE OF PHARMACOLOGIST		29. SIGNATURE OF TOXICOLOGIST		30. SIGNATURE OF EPIDEMIOLOGIST	
31. SIGNATURE OF PUBLIC HEALTH OFFICER		32. SIGNATURE OF HEALTH INSPECTOR		33. SIGNATURE OF LABORATORY ASSISTANT	
34. SIGNATURE OF RECORDS MANAGER		35. SIGNATURE OF CLERK		36. SIGNATURE OF RECEPTIONIST	
37. SIGNATURE OF MAIL ROOM		38. SIGNATURE OF JANITOR		39. SIGNATURE OF SECURITY GUARD	
40. SIGNATURE OF NIGHT WATCHMAN		41. SIGNATURE OF PEON		42. SIGNATURE OF PORTER	
43. SIGNATURE OF CLEANER		44. SIGNATURE OF COOK		45. SIGNATURE OF BUTLER	
46. SIGNATURE OF WAITRESS		47. SIGNATURE OF BAR TENDER		48. SIGNATURE OF BELL BOY	
49. SIGNATURE OF DOOR MAN		50. SIGNATURE OF Usher		51. SIGNATURE OF Ticket Collector	
52. SIGNATURE OF Conductor		53. SIGNATURE OF Fireman		54. SIGNATURE OF Police Officer	
55. SIGNATURE OF Sheriff		56. SIGNATURE OF Marshal		57. SIGNATURE OF Judge	
58. SIGNATURE OF Lawyer		59. SIGNATURE OF Doctor		60. SIGNATURE OF Nurse	
61. SIGNATURE OF Pharmacist		62. SIGNATURE OF Dentist		63. SIGNATURE OF Veterinarian	
64. SIGNATURE OF Engineer		65. SIGNATURE OF Architect		66. SIGNATURE OF Carpenter	
67. SIGNATURE OF Painter		68. SIGNATURE OF Electrician		69. SIGNATURE OF Plumber	
70. SIGNATURE OF Mechanic		71. SIGNATURE OF Welder		72. SIGNATURE OF Blacksmith	
73. SIGNATURE OF Farmer		74. SIGNATURE OF Miner		75. SIGNATURE OF Fisherman	
76. SIGNATURE OF Hunter		77. SIGNATURE OF Sailor		78. SIGNATURE OF Pilot	
79. SIGNATURE OF Captain		80. SIGNATURE OF Officer		81. SIGNATURE OF Soldier	
82. SIGNATURE OF Sailor		83. SIGNATURE OF Merchant		84. SIGNATURE OF Clerk	
85. SIGNATURE OF Janitor		86. SIGNATURE OF Porter		87. SIGNATURE OF Usher	
88. SIGNATURE OF Ticket Collector		89. SIGNATURE OF Conductor		90. SIGNATURE OF Fireman	
91. SIGNATURE OF Police Officer		92. SIGNATURE OF Sheriff		93. SIGNATURE OF Marshal	
94. SIGNATURE OF Judge		95. SIGNATURE OF Lawyer		96. SIGNATURE OF Doctor	
97. SIGNATURE OF Nurse		98. SIGNATURE OF Pharmacist		99. SIGNATURE OF Dentist	
100. SIGNATURE OF Veterinarian		101. SIGNATURE OF Engineer		102. SIGNATURE OF Architect	
103. SIGNATURE OF Carpenter		104. SIGNATURE OF Painter		105. SIGNATURE OF Electrician	
106. SIGNATURE OF Plumber		107. SIGNATURE OF Mechanic		108. SIGNATURE OF Welder	
109. SIGNATURE OF Blacksmith		110. SIGNATURE OF Farmer		111. SIGNATURE OF Miner	
112. SIGNATURE OF Fisherman		113. SIGNATURE OF Hunter		114. SIGNATURE OF Sailor	
115. SIGNATURE OF Pilot		116. SIGNATURE OF Captain		117. SIGNATURE OF Officer	
118. SIGNATURE OF Soldier		119. SIGNATURE OF Merchant		120. SIGNATURE OF Clerk	
121. SIGNATURE OF Janitor		122. SIGNATURE OF Porter		123. SIGNATURE OF Usher	
124. SIGNATURE OF Ticket Collector		125. SIGNATURE OF Conductor		126. SIGNATURE OF Fireman	
127. SIGNATURE OF Police Officer		128. SIGNATURE OF Sheriff		129. SIGNATURE OF Marshal	
130. SIGNATURE OF Judge		131. SIGNATURE OF Lawyer		132. SIGNATURE OF Doctor	
133. SIGNATURE OF Nurse		134. SIGNATURE OF Pharmacist		135. SIGNATURE OF Dentist	
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148. SIGNATURE OF Fisherman		149. SIGNATURE OF Hunter		150. SIGNATURE OF Sailor	
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157. SIGNATURE OF Janitor		158. SIGNATURE OF Porter		159. SIGNATURE OF Usher	
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163. SIGNATURE OF Police Officer		164. SIGNATURE OF Sheriff		165. SIGNATURE OF Marshal	
166. SIGNATURE OF Judge		167. SIGNATURE OF Lawyer		168. SIGNATURE OF Doctor	
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505. SIGNATURE OF Blacksmith		506. SIGNATURE OF Farmer		507. SIGNATURE OF Miner	
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529. SIGNATURE OF Nurse		530. SIGNATURE OF Pharmacist		531. SIGNATURE OF Dentist	
532. SIGNATURE OF Veterinarian		533. SIGNATURE OF Engineer		534. SIGNATURE OF Architect	
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541. SIGNATURE OF Blacksmith		542. SIGNATURE OF Farmer		543. SIGNATURE OF Miner	
544. SIGNATURE OF Fisherman		545. SIGNATURE OF Hunter		546. SIGNATURE OF Sailor	
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580. SIGNATURE OF Fisherman		581. SIGNATURE OF Hunter		582. SIGNATURE OF Sailor	
583. SIGNATURE OF Pilot		584. SIGNATURE OF Captain		585. SIGNATURE OF Officer	
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619. SIGNATURE OF Pilot		620. SIGNATURE OF Captain		621. SIGNATURE OF Officer	
622. SIGNATURE OF Soldier		623. SIGNATURE OF Merchant		624. SIGNATURE OF Clerk	
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667. SIGNATURE OF Police Officer		668. SIGNATURE OF Sheriff		669. SIGNATURE OF Marshal	
670. SIGNATURE OF Judge		671. SIGNATURE OF Lawyer		672. SIGNATURE OF Doctor	
673. SIGNATURE OF Nurse		674. SIGNATURE OF Pharmacist		675. SIGNATURE OF Dentist	
676. SIGNATURE OF Veterinarian		677. SIGNATURE OF Engineer		678. SIGNATURE OF Architect	
679. SIGNATURE OF Carpenter		680. SIGNATURE OF Painter		681. SIGNATURE OF Electrician	
682. SIGNATURE OF Plumber		683. SIGNATURE OF Mechanic		684. SIGNATURE OF Welder	
685. SIGNATURE OF Blacksmith		686. SIGNATURE OF Farmer		687. SIGNATURE OF Miner	
688. SIGNATURE OF Fisherman		689. SIGNATURE OF Hunter		690. SIGNATURE OF Sailor	
691. SIGNATURE OF Pilot		692. SIGNATURE OF Captain		693. SIGN	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3148

## CERTIFICATE OF DEATH

03142

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>3 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Lake Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>Box #337</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>John</u> Last <u>Edwards, Sr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coal mining (soft)</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-1306</u>		17. INFORMANT <u>Mrs. Carrie Edwards, Box 337, Mt. Lake Park, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Hemorrhoma Internal</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>56</u> , to <u>March 29, 1959</u> , that I last saw the deceased alive on <u>29 Mar</u> , 19 <u>59</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Md</u>		DATE SIGNED <u>20 Mar 59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Andrew E. Mance, M.D.</u>				<u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elk Garden, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

CONFIDENTIAL

CERTIFICATE OF DEATH

STATE OF MARYLAND

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
DATE OF REGISTRATION		PLACE OF REGISTRATION	

3149

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> M		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland</b>		c. LENGTH OF STAY IN 1b <b>60 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>× Rural Oakland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Mi. So. Oakland,</b>		d. STREET ADDRESS <b>5 Mi. So. Oakland,</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Custer</b> Last <b>Friend</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1872</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Emanuel Custer</b>		14. MOTHER'S MAIDEN NAME <b>Virginia DeWitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Otha Friend</b> Address <b>Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHIECTASIS-</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>JAN 19</b> , 19 <b>59</b> to <b>Jan 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 28</b> , 19 <b>59</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>25 ALDER ST. OAKLAND MD.</b> DATE SIGNED <b>3/3/59</b>					
ACTUAL SIGNATURE <b>E. L. PAUMGARTNER</b>		PHYSICIAN'S NAME (Type) <b>E. L. PAUMGARTNER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/4/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery, near Oakland, Md.</b>	
22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1877		New York City	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Coronary Artery Disease		Chest Pain, Shortness of Breath		Several Months		10:30 AM	
Place of Death		Occupation		Education		Marital Status		Religion	
Home		Teacher		High School		Married		Roman Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 15, 1922		10:30 AM		Home		Heart Disease		Coronary Artery Disease	
Signature of Coroner		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Cause of Certificate		Disease	
Jan 15, 1922		10:30 AM		Home		Heart Disease		Coronary Artery Disease	



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG240 3-26-59 et

3150

## CERTIFICATE OF DEATH

Items 8, 9 FilmG240 3-31-59 et

Reg. Dist. No.

03144

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>6 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		0102-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evans Nursing Home</u>		d. STREET ADDRESS <u>313 Foster Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Grimes</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 23, 1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>A-110-662</u>	
17. INFORMANT <u>Woodrow Grimes, Cumberland Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>My Grandson, kept good</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 and 3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 11, 1958</u> to <u>March 18, 1959</u> , that I lost the deceased on <u>March 18, 1959</u> , and that death occurred at <u>5:07 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>3522 DEN ST OAKLAND</u>	
ACTUAL SIGNATURE <u>E. L. BAUMGARTNER</u> M.D.		DATE SIGNED <u>3/10/59</u>	
PHYSICIAN'S NAME (Type) <u>E. L. BAUMGARTNER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3/24/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron R. Right</u>		ADDRESS <u>Cumberland Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fenn</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03145

3151

1. PLACE OF DEATH a. COUNTY <u>Oakland, Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Grant</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emoryville</u> <u>851-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>William</u> Last <u>Hipp</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>25</u> Hours <u>19</u> Min. <u>59</u>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Soft Coal mines</u>	
11. BIRTHPLACE (State or foreign country) <u>America (Iowa)</u>		12. CITIZEN OF WHAT COUNTRY? <u>America U.S.A.</u>	
13. FATHER'S NAME <u>Hipp, Frank</u>		14. MOTHER'S MAIDEN NAME <u>Bosley, Cindy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-12-8201</u>	
17. INFORMANT <u>Everson Hipp</u>		Address <u>Emoryville, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio</u> DUE TO (c) <u>Chronic disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>3-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>59</u> , and that death occurred at <u>1:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. J. H. Feaster, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>58 2nd St. Oakland, Md.</u> DATE SIGNED <u>3-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. H. Feaster, Jr.</u>		<u>Oakland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/27/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elk Garden, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u> ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huang</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

3152

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>Andrew</b> Last <b>KERINS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES KERINS</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET Melvin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-24-1267</b>	
17. INFORMANT <b>George Kerins</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Broncho pneumonia, Bilat.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1958</b> , to <b>March 30, 1959</b> , that I last saw the deceased alive on <b>30 Mar</b> , 1959, and that death occurred at <b>5:05 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>31 Mar 59</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.</b>		THIRD STREET <b>OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/2/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

VIDEIN 1924

1924

1924

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Date of burial</p>	
<p>9. Name of physician</p>		<p>10. Name of funeral director</p>	
<p>11. Name of undertaker</p>		<p>12. Name of cemetery</p>	
<p>13. Name of church</p>		<p>14. Name of minister</p>	
<p>15. Name of family</p>		<p>16. Name of next of kin</p>	
<p>17. Name of executor</p>		<p>18. Name of administrator</p>	
<p>19. Name of guardian</p>		<p>20. Name of trustee</p>	
<p>21. Name of agent</p>		<p>22. Name of agent</p>	
<p>23. Name of agent</p>		<p>24. Name of agent</p>	
<p>25. Name of agent</p>		<p>26. Name of agent</p>	
<p>27. Name of agent</p>		<p>28. Name of agent</p>	
<p>29. Name of agent</p>		<p>30. Name of agent</p>	
<p>31. Name of agent</p>		<p>32. Name of agent</p>	
<p>33. Name of agent</p>		<p>34. Name of agent</p>	
<p>35. Name of agent</p>		<p>36. Name of agent</p>	
<p>37. Name of agent</p>		<p>38. Name of agent</p>	
<p>39. Name of agent</p>		<p>40. Name of agent</p>	
<p>41. Name of agent</p>		<p>42. Name of agent</p>	
<p>43. Name of agent</p>		<p>44. Name of agent</p>	
<p>45. Name of agent</p>		<p>46. Name of agent</p>	
<p>47. Name of agent</p>		<p>48. Name of agent</p>	
<p>49. Name of agent</p>		<p>50. Name of agent</p>	
<p>51. Name of agent</p>		<p>52. Name of agent</p>	
<p>53. Name of agent</p>		<p>54. Name of agent</p>	
<p>55. Name of agent</p>		<p>56. Name of agent</p>	
<p>57. Name of agent</p>		<p>58. Name of agent</p>	
<p>59. Name of agent</p>		<p>60. Name of agent</p>	
<p>61. Name of agent</p>		<p>62. Name of agent</p>	
<p>63. Name of agent</p>		<p>64. Name of agent</p>	
<p>65. Name of agent</p>		<p>66. Name of agent</p>	
<p>67. Name of agent</p>		<p>68. Name of agent</p>	
<p>69. Name of agent</p>		<p>70. Name of agent</p>	
<p>71. Name of agent</p>		<p>72. Name of agent</p>	
<p>73. Name of agent</p>		<p>74. Name of agent</p>	
<p>75. Name of agent</p>		<p>76. Name of agent</p>	
<p>77. Name of agent</p>		<p>78. Name of agent</p>	
<p>79. Name of agent</p>		<p>80. Name of agent</p>	
<p>81. Name of agent</p>		<p>82. Name of agent</p>	
<p>83. Name of agent</p>		<p>84. Name of agent</p>	
<p>85. Name of agent</p>		<p>86. Name of agent</p>	
<p>87. Name of agent</p>		<p>88. Name of agent</p>	
<p>89. Name of agent</p>		<p>90. Name of agent</p>	
<p>91. Name of agent</p>		<p>92. Name of agent</p>	
<p>93. Name of agent</p>		<p>94. Name of agent</p>	
<p>95. Name of agent</p>		<p>96. Name of agent</p>	
<p>97. Name of agent</p>		<p>98. Name of agent</p>	
<p>99. Name of agent</p>		<p>100. Name of agent</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03147

Reg. Dist. No.

<b>3153</b>				<b>03147</b>			
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland.</u> <span style="float: right;">b. COUNTY <u>Garrett</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland</u>		c. LENGTH OF STAY IN 1b <u>6 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x <u>Mt. Lake Park,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home of Lewis VanSickle</u>				d. STREET ADDRESS <u>Loch Lynn</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>John Bance King</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 20, 1959</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 2, 1880</u>	
				<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Soft Coal Mines</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Arch King</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Biggs</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-07-6716</u>		<b>17. INFORMANT</b> Address <u>John R. King Mt. Lake Park, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				DATE SIGNED <u>3-20-59</u>			
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/22/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Deer Park Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Deer Park, Maryland.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. H. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAR 23 1959</u>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. Leighton</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]	
SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	

QUALITY OF LIFE  
 [REDACTED]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03148

Reg. Dist. No.

3154

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN lb <u>1 Hr. 50 Min</u> <span style="float: right;"><u>Rural</u> <u>Oakland</u></span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>Route # 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Dannie</u> Middle <u>Ray</u> Last <u>Miller</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>5</u> Year <u>19 59</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>January 27, 54</u>			
<b>9. AGE</b> (In years last birthday) <u>5</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Oakland, Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>							
<b>13. FATHER'S NAME</b> <u>Joni J. Miller</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Fannie J. Miller</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Route # 2</u> <u>"Father" Joni J. Miller, Oakland, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <u>204.1</u> IMMEDIATE CAUSE (a) <u>Spontaneous Intracranial hemorrhage, diffuse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute mylogenous leukemia</u> DUE TO (c) <u>  </u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James H. Feaster Jr.</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>James H. Feaster Jr. M. D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>3-5-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/7/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Slabaugh Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> (State) <u>near Oakland, Md.</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. C. Leighton</u>		<b>ADDRESS</b> <u>Oakland, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>MAR 11 '59</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <span style="float: right;">3153</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gorman</b> c. LENGTH OF STAY IN 1b <b>16 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 Mi. West Gorman, Route #50</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gorman</b> d. STREET ADDRESS <b>2 Mi. West Gorman, Route 50</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Joseph</b> Last <b>Moreland</b>			4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1957</b>		9. AGE (In years last birthday) <b>1</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Roy G. Moreland</b>			14. MOTHER'S MAIDEN NAME <b>Selma Jordan</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Roy G. Moreland R. D. Gorman, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, right upper lobe</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Dehydration, marked</b> (c) <b>493x</b> DUE TO (c) <b>24 hrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>3-12-59</b>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/14/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Route #50, near Gorman, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-CARDS, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

3156

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland,</b>		c. LENGTH OF STAY IN 1b <b>88 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. #2 Oakland,</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W.</b> Last <b>Nine</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1870</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Peter Nine</b>	
14. MOTHER'S MAIDEN NAME <b>Charlotte Whitehair</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Mrs. Charles Nine R. D. Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>dissection</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 5, 1955</b> to <b>March 6, 1959</b> , that I last saw the deceased alive on <b>March 4, 1959</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Harriman</b> M.D.		ADDRESS (Street, city or town, state) <b>Terra Alta, W. Va.</b> DATE/SIGNED <b>3/17/59</b>	
PHYSICIAN'S NAME (Type) <b>William Harriman, M. D.</b>		<b>Terra Alta, W. Va.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/8/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Nine Home Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>near Oakland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03151

3157

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Grantsville, Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)      First      Middle      Last <u>DAVID</u> <u>EUGENE</u> <u>SHUMAKER</u>				<b>4. DATE OF DEATH</b> Month      Day      Year <u>March</u> <u>7</u> <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1948</u>	
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months      Days      Hours      Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Grantsville elem.</u>		11. BIRTHPLACE (State or foreign country) <u>Grantville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Step. Jacob R. Gnagy Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Dorothy Shumaker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Dorothy Gnagy,</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIATION ; PULMONARY EDEMA</u> DUE TO (b) <u>ACUTE TRACHEOBRONCHITIS, MILD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Also: LARYNGEAL EDEMA, MARKED</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>  <u>12 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HISTORY OF ASTHMA</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour      a. m.      p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James H. Feaster Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3-7-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Con J Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

3158

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park</b> c. LENGTH OF STAY IN lb <b>10 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1 mile west Deer Park</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park</b> d. STREET ADDRESS <b>1 Mile West Deer Park</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Ellen</b> Last <b>Smouse</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Georgg Shartzter</b>	
14. MOTHER'S MAIDEN NAME <b>Hester Conneway</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Albert Smouse</b> Address <b>R.D. Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V.D. with Arteriosclerosis</b> (c) <b>Diabetes Mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/31</b> , 19 <b>57</b> , to <b>3/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/17</b> , 19 <b>57</b> , and that death occurred at <b>5:30P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew S Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>9 March 1959</b>	
PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		<b>Oakland, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/11/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Reighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Faint text, possibly "JOHN DOE"]</p>		<p>AGE                  [Faint text, possibly "45"]</p>		<p>SEX                  [Faint text, possibly "Male"]</p>	
<p>DATE OF DEATH                  [Faint text, possibly "1945-10-15"]</p>		<p>TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>		<p>PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>		<p>EDUCATION                  [Faint text, possibly "High School Graduate"]</p>	
<p>DATE OF BIRTH                  [Faint text, possibly "1900-10-15"]</p>		<p>PLACE OF BIRTH                  [Faint text, possibly "Maryland"]</p>		<p>OCCUPATION                  [Faint text, possibly "Teacher"]</p>	
<p>DATE OF DEATH                  [Faint text, possibly "1945-10-15"]</p>		<p>TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>		<p>PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>		<p>EDUCATION                  [Faint text, possibly "High School Graduate"]</p>	
<p>DATE OF BIRTH                  [Faint text, possibly "1900-10-15"]</p>		<p>PLACE OF BIRTH                  [Faint text, possibly "Maryland"]</p>		<p>OCCUPATION                  [Faint text, possibly "Teacher"]</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for removal.

VS. A15ME(5)  
5M 9/55

1  
3159 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03153  
Item 9 Film 240 4-2-59 et Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>VIRGINIA</u> Middle <u>AUGUSTA</u> Last <u>YOUNKIN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE (In years last birthday) <u>17/63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Bowser</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Cuschlag</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs Beulah Youmer, Grantsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u> <u>4 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER JR.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-24-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville,</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

